EDMUND G. BROWN JR.
Attorney General of California
FRANK H. PACE
Supervising Deputy Attorney General
JUDITH J. LOACH
Deputy Attorney General
State Bar No. 162030
455 Golden Gate Avenue, Suite 11000
San Francisco, CA 94102-7004
Telephone: (415) 703-5604
Facsimile: (415) 703-5480
E-mail: Judith.Loach@doj.ca.gov
Attorneys for Complainant

BEFORE THE
BOARD OF REGISTERED NURSING
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **SHELLEY RUCKER** **110 Golf Course Drive, Apt. 304** **Rohnert Park, CA 94928** **Registered Nursing License No. 640085,** Respondent.	Case No. 2010-104 **ACCUSATION**

Complainant alleges:

PARTIES

1. Louise R. Bailey, M.Ed., RN ("Complainant") brings this Accusation solely in her official capacity as the Interim Executive Officer of the Board of Registered Nursing, Department of Consumer Affairs.

2. On or about July 12, 2004, the Board of Registered Nursing issued Registered Nursing License Number 640085 to Shelley Rucker ("Respondent"). The Registered Nursing License was in full force and effect at all times relevant to the charges brought herein and expired on September 30, 2005, and has not been renewed.

JURISDICTION

3. This Accusation is brought before the Board of Registered Nursing ("Board"), Department of Consumer Affairs, under the authority of the following laws. All section references are to the Business and Professions Code unless otherwise indicated.

4. Section 2761 of the Code states:

"The board may take disciplinary action against a certified or licensed nurse or deny an application for a certificate or license for any of the following:

"(a) Unprofessional conduct, which includes, but is not limited to, the following:

"(1) Incompetence, or gross negligence in carrying out usual certified or licensed nursing functions.

. . .

"(4) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license or certificate by another state or territory of the United States, by any other government agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

. . .

5. Section 2762 of the Code states:

"In addition to other acts constituting unprofessional conduct within the meaning of this chapter [the Nursing Practice Act], it is unprofessional conduct for a person licensed under this chapter to do any of the following:

"(a) Obtain or possess in violation of law, or prescribe, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administer to himself or herself, or furnish or administer to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug or dangerous device as defined in Section 4022.

(b) Use of any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drugs or dangerous device as identified

in Section 4022, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that such use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

. . .

"(e) Falsify, or make grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a) of this section."

6. Section 2750 of the Business and Professions Code ("Code") provides, in pertinent part, that the Board may discipline any licensee, including a licensee holding a temporary or an inactive license, for any reason provided in Article 3 (commencing with section 2750) of the Nursing Practice Act.

7. Section 2764 of the Code provides, in pertinent part, that the expiration of a license shall not deprive the Board of jurisdiction to proceed with a disciplinary proceeding against the licensee or to render a decision imposing discipline on the license.

8. Section 125.3 of the Code provides, in pertinent part, that the Board may request the administrative law judge to direct a licentiate found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

DRUGS

9. "Dilaudid" is the trade name for Hydromorphone, a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(K) and dangerous drug per Code section 4022. Dilaudid is packaged in ampoules containing 1 milligram, 2 milligrams or 4 milligrams per milliliter. It is a narcotic analgesic equivalent to Morphine Sulfate.

10. "Morphine Sulfate" is a Schedule II controlled substance pursuant to Health and Safety Code section 11055(b)(1)(M) and dangerous drug per Code section 4022. This medication is a potent opioid analgesic for relief of moderate to severe pain.

11. "Norco" is the trade name for Hydrocodone 5 milligrams/Acetaminophen 325 milligrams, and a Schedule II controlled substance pursuant to Health and Safety Code section

11056(e)(4) and dangerous drug per Code section 4022. This medication is in the class of narcotic analgesics and used for the treatment of moderate to severe pain.

FIRST CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

12. Respondent is subject to disciplinary action under Code section 2761(a) in that she acted unprofessionally. The circumstances are as follows:

13. From November 1, 2004 to November 22, 2004, Respondent was employed as a Licensed Registered Nurse at Santa Rosa Memorial Hospital, Santa Rosa, California. On November 21, 2004, Respondent exhibited bizarre behavior, including but not limited to: labile moods, ranging from being calm, to angry and out of control, all within a short period of time; leaving the nursing unit for multiple breaks lasting longer than 30 minutes that coincided with when she was administering medications to her assigned patients; confused behavior in that she charted on the wrong patients and entered Physician Orders in the wrong patient charts.

14. As a result of the erratic mood swings and charting errors as set forth in paragraph 13, Respondent was asked to and did submit to a urine drug screen on November 22, 2004. The test results came back as "negative diluted." When asked to submit another specimen, Respondent refused and stated that she had a major substance abuse problem.

SECOND CAUSE FOR DISCIPLINE

(False Entries in Hospital, Patient or Other Records)

15. Respondent is subject to disciplinary action under Code section 2671(a) on the grounds of unprofessional conduct, as defined by Code sections 2762(a) and 2762(e), in that while on duty as a Licensed Registered Nurse at Santa Rosa Memorial Hospital, Santa Rosa, California, she falsified, made grossly incorrect, grossly inconsistent, or unintelligible entries in hospital and patient records in the following circumstances:

Patient A:

a. On November 6, 2004, at 7:24 p.m., Respondent withdrew Dilaudid 4 mg/ml, a controlled substance, from the Pyxis for Patient A, when the Physician's Order called for Dilaudid 1-2 mg every hour for pain. Respondent failed to chart in the Medication Record that

any Dilaudid was administered to Patient A and failed to account for the disposition of the 4 mg of Dilaudid.

b. On November 6, 2004, at 9:03 p.m., Respondent withdrew Dilaudid 4 mg/ml, a controlled substance, from the Pyxis for Patient A, when the Physician's Order called for Dilaudid 1-2 mg every hour for pain. Respondent failed to chart in the Medication Record that Dilaudid was administered to Patient A and failed to account for the disposition of the 4 mg of Dilaudid.

Patient B:

c. On November 1, 2004, at 10:45 p.m., Respondent withdrew two Norco tablets, a controlled substance, from the Pyxis for Patient B, with the Physician's Order providing for Norco 5 mg/325 mg, 1-2 tablets by mouth every four hours as needed for pain. Respondent charted administering the Norco to Patient B, at 10:30 p.m., 15 minutes prior to the time that said medication was removed from the Pyxis.

Patient C:

d. On November 1, 2004, at 9:54 p.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient C, when the Physician's Order called for 1-5 mg of Morphine Sulfate to be administered intravenously every hour as needed for pain. In the medication record Respondent charted administering 5 mg of Morphine Sulfate to Patient C at 10:00 p.m. However, Respondent failed to chart having administered this medication in the nursing notes for Patient C and failed to account for the disposition of the remaining 5 mg of Morphine Sulfate.

e. On November 7, 2004, at 10:44 p.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient C, when the Physician's Order called for 1-5 mg of Morphine Sulfate to be administered intravenously every hour as needed for pain. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 10 mg of Morphine Sulfate.

f. On November 10, 2004, at 7:23 p.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient C, when the Physician's Order called

for 1-5 mg of Morphine Sulfate to be administered intravenously every hour as needed for pain. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 10 mg of Morphine Sulfate.

g. On November 10, 2004, at 7:52 p.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient C, when the Physician's Order called for 1-5 mg of Morphine Sulfate to be administered intravenously every hour as needed for pain. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 10 mg of Morphine Sulfate.

h. On November 12, 2004, at 12:08 a.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient C, when the Physician's Order called for 1-5 mg of Morphine Sulfate to be administered intravenously every hour as needed for pain. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 10 mg of Morphine Sulfate.

i. On November 12, 2004, at 2:02 a.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient C, when the Physician's Order called for 1-5 mg of Morphine Sulfate to be administered intravenously every hour as needed for pain. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 10 mg of Morphine Sulfate.

j. On November 12, 2004, at 6:23 a.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient C, when the Physician's Order called for 1-5 mg of Morphine Sulfate to be administered intravenously every hour as needed for pain. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 10 mg of Morphine Sulfate.

Patient D:

k. On November 8, 2004, at 12:02 a.m., Respondent withdrew one 4 mg Dilaudid tablet, a controlled substance, from the Pyxis for Patient D, with the Physician's Order calling for Dilaudid 4 mg tablet every three hours as needed for pain. Respondent charted administering the

Dilaudid to Patient D at 4:00 a.m., almost four hours after this medication was removed from the Pyxis.

l. On November 8, 2004, at 4:50 a.m., Respondent withdrew one 4 mg Dilaudid tablet, a controlled substance, from the Pyxis for Patient D, with the Physician's Order calling for Dilaudid 4 mg tablet every three hours as needed for pain. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 4 mg tablet of Dilaudid.

m. On November 8, 2004, at 6:25 a.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient D, when the Physician's Order called for 4 mg of Morphine Sulfate to be administered intravenously three times a day as needed for dressing changes. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 10 mg of Morphine Sulfate.

n. On November 11, 2004, at 3:54 a.m., Respondent withdrew one 4 mg Dilaudid tablet, a controlled substance, from the Pyxis for Patient D, with the Physician's Order calling for Dilaudid 4 mg tablet every three hours as needed for pain. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 4 mg tablet of Dilaudid.

o. On November 15, 2004, at 8:02 p.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient D, when the Physician's Order called for 4 mg of Morphine Sulfate to be administered intravenously three times a day as needed with dressing changes. In the medication record Respondent charted administering 4 mg of Morphine Sulfate to Patient D at 8:00 p.m., two minutes prior to the medication being withdrawn from the Pyxis. Respondent failed to chart having administered this medication in association with changing the Patient D's dressing as ordered and failed to account for the disposition of the remaining 6 mg of Morphine Sulfate.

p. On November 15, 2004, at 8:25 p.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient D, when the Physician's Order called

for 4 mg of Morphine Sulfate to be administered intravenously three times a day as needed with dressing changes. Respondent failed to chart having administered this medication in association with changing the Patient D's dressing as ordered, failed to document the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 10 mg vial of Morphine Sulfate.

q. On November 15, 2004, at 11:56 p.m., Respondent withdrew one 4 mg Dilaudid tablet, a controlled substance, from the Pyxis for Patient D, with the Physician's Order calling for Dilaudid 4 mg tablet every three hours as needed for pain. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 4 mg tablet of Dilaudid.

r. On November 16, 2004, at 12:25 a.m., Respondent withdrew one 4 mg Dilaudid tablet, a controlled substance, from the Pyxis for Patient D, with the Physician's Order calling for Dilaudid 4 mg tablet every three hours as needed for pain. Respondent charted administering the Dilaudid to Patient D at 2:00 a.m., one and one half hours after removal of this medication from the Pyxis.

THIRD CAUSE FOR DISCIPLINE

(Use of Controlled Substance to an Extent or in a Manner Dangerous or Injurious to the Licensee and/or Others)

16. Respondent is subject to disciplinary action under Code section 2671(a) on the grounds of unprofessional conduct, as defined by Code sections 2762(b), in that while on duty as a Licensed Registered Nurse at Santa Rosa Memorial Hospital, Santa Rosa, California, Respondent used a controlled substance, to an extent or in a manner dangerous or injurious to herself and/or others as set forth below:

Patient A:

a. On November 6, 2004, at 7:24 p.m., Respondent withdrew Dilaudid 4 mg/ml, a controlled substance, from the Pyxis for Patient A, when the Physician's Order called for Dilaudid 1-2 mg every hour for pain. Respondent failed to chart in the Medication Record that

any Dilaudid was administered to Patient A and failed to account for the disposition of the 4 mg of Dilaudid.

b. On November 6, 2004, at 9:03 p.m., Respondent withdrew Dilaudid 4 mg/ml, a controlled substance, from the Pyxis for Patient A, when the Physician's Order called for Dilaudid 1-2 mg every hour for pain. Respondent failed to chart in the Medication Record that Dilaudid was administered to Patient A and failed to account for the disposition of the 4 mg of Dilaudid.

Patient C:

c. On November 1, 2004, at 9:54 p.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient C, when the Physician's Order called for 1-5 mg of Morphine Sulfate to be administered intravenously every hour as needed for pain. In the medication record Respondent charted administering 5 mg of Morphine Sulfate to Patient C at 10:00 p.m. However, Respondent failed to chart having administered this medication in the nursing notes for Patient C and failed to account for the disposition of the remaining 5 mg of Morphine Sulfate.

d. On November 7, 2004, at 10:44 p.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient C, when the Physician's Order called for 1-5 mg of Morphine Sulfate to be administered intravenously every hour as needed for pain. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 10 mg of Morphine Sulfate.

e. On November 10, 2004, at 7:23 p.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient C, when the Physician's Order called for 1-5 mg of Morphine Sulfate to be administered intravenously every hour as needed for pain. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 10 mg of Morphine Sulfate.

f. On November 10, 2004, at 7:52 p.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient C, when the Physician's Order called for 1-5 mg of Morphine Sulfate to be administered intravenously every hour as needed for pain.

Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 10 mg of Morphine Sulfate.

g. On November 12, 2004, at 12:08 a.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient C, when the Physician's Order called for 1-5 mg of Morphine Sulfate to be administered intravenously every hour as needed for pain. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 10 mg of Morphine Sulfate.

h. On November 12, 2004, at 2:02 a.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient C, when the Physician's Order called for 1-5 mg of Morphine Sulfate to be administered intravenously every hour as needed for pain. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 10 mg of Morphine Sulfate.

i. On November 12, 2004, at 6:23 a.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient C, when the Physician's Order called for 1-5 mg of Morphine Sulfate to be administered intravenously every hour as needed for pain. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 10 mg of Morphine Sulfate.

Patient D:

j. On November 8, 2004, at 4:50 a.m., Respondent withdrew one 4 mg Dilaudid tablet, a controlled substance, from the Pyxis for Patient D, with the Physician's Order calling for Dilaudid 4 mg tablet every three hours as needed for pain. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 4 mg tablet of Dilaudid.

k. On November 8, 2004, at 6:25 a.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient D, when the Physician's Order called for 4 mg of Morphine Sulfate to be administered intravenously three times a day as needed for dressing changes. Respondent failed to chart the administration of this medication in the

medication record and/or nursing notes and failed to account for the disposition of the 10 mg of Morphine Sulfate.

l. On November 11, 2004, at 3:54 a.m., Respondent withdrew one 4 mg Dilaudid tablet, a controlled substance, from the Pyxis for Patient D, with the Physician's Order calling for Dilaudid 4 mg tablet every three hours as needed for pain. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 4 mg tablet of Dilaudid.

m. On November 15, 2004, at 8:02 p.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient D, when the Physician's Order called for 4 mg of Morphine Sulfate to be administered intravenously three times a day as needed with dressing changes. In the medication record Respondent charted administering 4 mg of Morphine Sulfate to Patient D at 8:00 p.m., two minutes prior to the medication being withdrawn from the Pyxis. Respondent failed to chart having administered this medication in association with changing the Patient D's dressing as ordered and failed to account for the disposition of the remaining 6 mg of Morphine Sulfate.

n. On November 15, 2004, at 8:25 p.m., Respondent withdrew a 10 mg vial of Morphine Sulfate, a controlled substance, from the Pyxis for Patient D, when the Physician's Order called for 4 mg of Morphine Sulfate to be administered intravenously three times a day as needed with dressing changes. Respondent failed to chart having administered this medication in association with changing the Patient D's dressing as ordered, failed to document the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 10 mg vial of Morphine Sulfate.

o. On November 15, 2004, at 11:56 p.m., Respondent withdrew one 4 mg Dilaudid tablet, a controlled substance, from the Pyxis for Patient D, with the Physician's Order calling for Dilaudid 4 mg tablet every three hours as needed for pain. Respondent failed to chart the administration of this medication in the medication record and/or nursing notes and failed to account for the disposition of the 4 mg tablet of Dilaudid.

FOURTH CAUSE FOR DISCIPLINE

(Disciplinary action by another state)

17. Respondent is subject to disciplinary action under section 2761(a)(4) in that she acted unprofessionally. The circumstances are as follows:

18. On or about June 5, 2008, in a prior disciplinary action entitled *In the Matter of: Shelley Rucker, RN*, Registered Nurse License No. 118140, before the State of Tennessee, Department of Health, Board of Nursing, Case Number 200601186, Respondent's Registered Nursing License was suspended for unprofessional conduct pursuant to the Tennessee Nurse Practice Act. The Stipulations of Fact regarding the suspension recited that "Respondent was terminated (from Saint Francis Hospital in Memphis) for several occurrences involving unruly behavior, excessive tardiness, suspicions of drug diversion and suspicion of removing a prescription from a patient's chart, as well as appearing impaired." The Consent Order was approved by the Board of Nursing on June 5, 2008, and is attached hereto and incorporated by reference as Exhibit A.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Board of Registered Nursing issue a decision:

1. Revoking or suspending Registered Nursing License Number 640085, issued to Shelley Rucker.

2. Ordering Shelley Rucker to pay the Board of Registered Nursing the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3;

3. Taking such other and further action as deemed necessary and proper.

DATED: 8/28/09

Louise R. Bailey

LOUISE R. BAILEY, M.ED., RN
Interim Executive Officer
Board of Registered Nursing
Department of Consumer Affairs
State of California
Complainant

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Exhibit A

Tennessee Department of Health
Bureau of Health Licensure & Regulation
Office of Investigations
Heritage Place MetroCenter
227 French Landing, Suite 201
Nashville, TN 37243
Toll Free 1-800-852-2187 or 615-532-3421 Facsimile 615-532-2499

March9, 2009

I, Juanita K. Stone, Disciplinary Coordinator, do hereby certify that the attached Consent Order on Shelley G. Rucker, R.N., license number, 118140 is a true and correct copy of the disciplinary order on file in this Office.

Juanita K. Stone
Disciplinary Coordinator
Tennessee Department of Health
Investigations Division

STATE OF TENNESSEE
DEPARTMENT OF HEALTH

IN THE MATTER OF:	)	**BEFORE THE BOARD OF NURSING**
	)	
SHELLEY G. RUCKER, RN	)	**Case Nos. 200601186**
RESPONDENT	)	
	)	
BARTLETT TENNESSEE	)	
LICENSE NO. 118140	)	

CONSENT ORDER

This matter came to be heard before the Tennessee Board of Nursing (hereinafter referred to as the "Board") on the 4th day of February, 2008, pursuant to the request of the Tennessee Department of Health, by and through the Board of Nursing Screening Panel which met on January 22, 2008, and the Respondent, Shelley G. Rucker, RN (hereinafter referred to as the "Respondent") that the Board adopt this Consent Order, the terms of which have been agreed upon by the parties, as signified by their signatures below.

The Board is responsible for the regulation and supervision of registered, practical, and advanced practice nurses licensed to practice nursing in the State of Tennessee. See Tennessee Nurse Practice Act, Tennessee Code Annotated Section (hereinafter referred to as "TENN. CODE ANN. §") 63-7-101, *et seq.* It is the policy of the Board to require strict compliance with the laws of this State, and to apply the law so as to preserve the quality of nursing care provided in Tennessee. It is also the duty and responsibility of the Board to promote and protect the public health, safety and welfare by disciplining nurses who violate the provisions of TENN. CODE ANN. § 63-7-101, *et seq.*

Respondent Shelley G. Rucker, RN by signature to this Order, waives the right to a contested case hearing and any and all rights to judicial review of this matter.

Respondent agrees that presentation to and consideration of this Consent Order by the Board for ratification and all matters divulged during that process shall not constitute unfair disclosure such that the Board or any of its members shall be prejudiced to the extent that requires their disqualification from hearing this matter should the Consent Order not be ratified. Likewise, all matters, admissions and statements disclosed or exchanged during the attempted ratification process shall not be used against the Respondent in any subsequent proceeding unless independently entered into evidence or introduced as admissions.

STIPULATIONS OF FACT

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1. Respondent was at all times pertinent hereto licensed by the Board as a registered nurse in th1999. Having been granted license number 118140. Respondent's license expires on August 31, 2008.
2. Respondent was employed with Saint Francis Hospital in Memphis, Tennessee from December 13, 2004 until August 15, 2006.
3. Respondent was allegedly terminated for several occurrences involving unruly behavior, excessive tardiness, suspicions of drug diversion and suspicion of removing a prescription from a patient's chart, as well as appearing impaired.
4. Respondent failed to obtain her Tennessee Nursing License within thirty (30) days of having changed her address from Mississippi to Tennessee.

5. Respondent was referred to the Employee Assistance Program (EAP) although she did not admit to taking the prescription. She said she has never had a problem with drugs or alcohol, however; she did admit that she takes Lortab for menstrual cramps.

GROUNDS FOR DISCIPLINE

The facts stipulated to in the Stipulations of Fact are sufficient to establish that grounds for discipline of the Respondent's nursing license exist. Specifically, Respondent has violated the following statutes, which are part of the Tennessee Nurse Practice Act found in Tennessee Code Annotated Section (hereinafter "T.C.A. §"), 63-7-101, *et seq.* and rules, which are part of The Official Compilation Rules and Regulations of the State of Tennessee for The Tennessee Board of Nursing (hereinafter "Rule"), 1000-1-.01, *et seq.*, for which disciplinary action before and by the Board is authorized.

6. **T.C.A. § 63-7-115. Grounds for denial, revocation or suspension of certificate or license.** – (a)(1) The board has the power to deny, revoke or suspend any certificate or license to practice nursing or to otherwise discipline a licensee upon proof that the person:

(A) Is guilty of fraud or deceit, in procuring or attempting to procure a license to practice nursing

(F) Is guilty of unprofessional conduct; and

7. **Rule 1000-1-.13. Unprofessional Conduct and Negligence, Habits or Other Cause.** - (1) Unprofessional conduct, unfitness, or incompetency by reasons of negligence, habits or other causes, as those terms are used in the statute, is defined as, but not limited to, the following:

(w) Engaging in acts of dishonesty which relate to the practice of nursing.

POLICY STATEMENT

8. The Tennessee Board of Nursing is responsible for the regulation and supervision of the practice of nursing in the State of Tennessee. TENN. CODE ANN. § 63-7-101 *et seq.*

9. It is the duty and responsibility of the Board of Nursing to enforce the Nurse Practice Act in such a manner as to insure that nurses use their licenses to promote and protect the public health, safety and welfare.

10. It is the policy of the Tennessee Board of Nursing to require strict compliance with the laws of this State and to apply the laws so as to preserve the quality of nursing care provided in Tennessee.

11. It is the duty and responsibility of the Tennessee Board of Nursing to promote the public health, safety and welfare by disciplining nurses who violate the provisions of TENN. CODE ANN. § 63-7-101 *et seq.*

NOW THEREFORE, Respondent, for the purpose of avoiding further administrative action with respect to this cause, agrees to the following:

12. The license of Respondent to practice nursing in Tennessee and multi-state privilege to practice in a party state, pursuant to the authority vested in the Board under T.C.A. §§ 63-7-115 and 116 shall be and is hereby placed on **SUSPENSION.**

13. Respondent shall have a substance abuse evaluation with the Tennessee Professional Assistance Program (hereinafter "TnPAP") within thirty (30) days of the effective date of the order and shall follow all recommendations of the evaluation.

14. The **SUSPENSION** shall be lifted only after a contract is signed and the Respondent receives clearance from TnPAP that she is sufficiently fit to resume the duties and activities associated with registered professional nursing.

15 Respondent's license shall then be placed on **PROBATION** to run concurrent with said TnPAP contract, and will continue until such time as the Respondent complies with each and every term of the contract, but shall be no less than three (3) years in duration. Should Respondent's contract with TnPAP be extended, the term of probation of Respondent's license shall also be extended to the new term of the TnPAP contract.

16. Respondent, while on **PROBATION**, agrees to limit her practice of nursing to Tennessee and not to practice in any party state during **PROBATION**, or, in the alternative, Respondent may practice in other party states with prior authorization from both the home state and such other party state boards, Tenn. Comp. R. & Regs. 1000-1-.17(3).

17. Respondent's **SUSPENSION/PROBATION** shall be effective the date this Consent Order is ratified by the Board.

18. Respondent agrees to the release of information from the screening panel if this matter comes before the Tennessee Board of Nursing as a contested case.

19. Respondent expressly waives all further procedural steps and expressly waives all rights to seek judicial review of or to challenge or contest the validity of this Consent Order.

20. Respondent understands that by signing this Consent Order, Respondent is allowing the Board to issue its order without further process. In the event that the Board rejects this Consent Order for any reason, it will be of no force or effect for either party.

21. A **violation** of this Order shall constitute a **separate violation** of the Nurse Practice Act, TENN. CODE ANN. § 63-7-115(a)(1)(G), and is grounds for further disciplinary action by the Board.

This **CONSENT ORDER** approved by a majority of a quorum of the Board at a public meeting and signed this 5th day of June, 2008.

FOR THE TENNESSEE BOARD OF NURSING:

Cheryl Stephens

Chairperson

AGREED TO AND APPROVED FOR ENTRY:

Shelley G. Rucker, RN, License No. 118140
Respondent

5/14/08
Date

PREPARED FOR ENTRY:

Wilma T. James (BPR # 022136)
Deputy General Counsel
Department of Health
Plaza 1, Suite 210
220 Athens Way
Nashville, Tennessee 37243
(615) 741-1611

June 4, 2008
Date

CERTIFICATE OF SERVICE

I certify that a true and correct copy of the foregoing has been served upon the Respondent, Shelley G. Rucker, R.N. 6870 Deerfield Road Bartlett, Tennessee 38135 by placing same in the United Parcel Certified Mail Tracking Number **7004 0550 0000 9792 7346**, return receipt requested, with sufficient postage thereon to reach its destination.

This 18th day of June, 2008.

Wilma T. James
Deputy General Counsel